A Pot Pourri of Pearls for Practice from the Professionals

The format of the Saskatchewan Chapter's Family Practice Review meant that speakers dealt with one or two points rather than a complete description of the whole topic. Here's a selection of tips from the pros:

J. W. Gerrard, MD, pediatrician, Saskatoon:

"Bedwetting runs in families. The enuretic child has one chance in three of having a parent who was also enuretic; their brothers and sisters are twice as likely to be enuretic as are the brothers and sisters of non-enuretics. Children with nocturnal enuresis have smaller maximum bladder capacities . . . 25 percent become dry when taken off a few common foods (cow's milk, chocolate, citrus fruits, tomato products and foods and drinks containing food colors). The children who become dry also experience an increase in bladder capacity".

Nathan Goluboff, MD, pediatrician, Saskatoon:

"High blood sugar levels in children can often mean salicylate poisoning. Oil of wintergreen is the most dangerous cause of salicylate toxicity. One teaspoonful contains the equivalent of almost 12 adult aspirins and may be fatal for a two year old. The Phenistix test is a quick way to find out whether salicylate poisoning is present – you don't want to wait around. Test the urine: if it's negative, it's not salicylate poisoning. If it's positive, *test the serum.* Then if it's negative, it's not salicylate poisoning. If it's positive, it's *probably* salicylate poisoning and you should proceed from there . . .

Doctors don't specify dosage and length of aspirin therapy clearly enough. Therapeutic overdosage over a period of a few days may cause some of the most severe poisonings. Tell mothers not to give aspirin oftener than every four hours. Remember that blood levels tend to pyramid. It takes 24-30 hours to excrete a single dose, and critical levels may be reached after a few days when excessive doses are used. In sick infants, aspirin should only be used for short term symptomatic relief – not more than a few days. Make your advice specific. *Don't* order 'a little aspirin' without explanation".

Elizabeth Ives, MD, geneticist, Saskatoon:

"If you're going to do genetic counselling, make sure you're prepared to verify the diagnosis. You could be affecting the reproductive pattern of generations. The majority of your advice will be reassurance. Even where the risk is high, pregnancy can be monitored and the couple do have another child, whereas without it (genetic counselling) they might never have tried. Your main objective is to help people make *informed* decisions about reproduction. Remember – one can never guarantee normality for any offspring".

James Leakos, MD, otolaryngologist, Saskatoon:

"Never lie little ones down when examining their ears. Sit them in mother's lap and give them a bottle if necessary – all crying kids have red eardrums . . . (in prophylaxis of otitis media) Never feed a baby when it's lying on its back! Look in your hospitals – I'll bet you'll find the babies are fed lying on their backs. Babies have short eustachian tubes and so are much more prone to infection . . .

Unresolved infection of the ear is still the commonest cause of brain abscess. The symptoms are: fever, headshaking, irritability (wakes up crying), GI complaints, nasal congestion.

If there is perforation of the eardrum and no discharge, *never* use eardrops. They'll cause an infection and the ear will start draining. I rarely use eardrops, except for relieving pain in acute bacterial otitis media."

J. W. A. MacKenzie, MD, pediatrician, Saskatoon:

"Dehydration is often a 'telephone complaint' and you want to find out if you have to get up in the middle of the night. If mother says, 'Johnny has diarrhea', you want to ask: 'How long? How big and how loose? How often? Is he vomiting? Drinking? Active?' If he's inactive and listless, he *must* be seen . . . If he's more than ten percent dehydrated, he'll require IV fluids. At ten percent, he's grey, inactive, lethargic, cyanosed with cold extremities, drinking poorly, vomiting and passing scanty urine. Administer five percent dextrose in water, plus quarter strength normal saline".

A. K. Teckchandani, MD, obstetrician, North Battleford:

"In practical situations, labor-inhibiting drugs are seldom necessary; the majority of patients presenting with premature labor will either continue to delivery of the fetus or to cessation of uterine contractions . . . Maximum salvage of premature infants will be provided by better maternal nutrition and more intensive prenatal care. Special attention given to patients with multiple pregnancies, repeat prematurity, toxemia, and familial congenital anomalies will provide the early clues for further successes in the management of prematurity associated with labor prior to 35 weeks of gestation."

Fergus O'Keefe, MD, obstetrician, Saskatoon:

"The very large baby, twins, hydramnios or multiparous mother all present risks of postpartum hemorrhage . . . For prophylaxis, in the third stage – *take your time.* Don't squeeze the uterus. Gently push when ready. Inspect the placenta and membranes – if any is retained, examine the uterus. Put a time limit on it: after 30 minutes if the placenta hasn't been delivered, remove it manually. The main method of controlling bleeding is the contraction and retraction of the uterus – it can't contract adequately until the placenta is out. Give oxytocin, have blood crossmatched, rub up a contraction, find the placenta and extract it if necessary."

T. J. McHattie, MD, obstetrician, Regina:

"The key to recognition of the high risk pregnancy is a good obstetrical history. There is a tremendous tendency to repeat problems. A previous fetal death or stillbirth gives double the risk of a second, or low birth weight. A low birth weight infant triples the risk of having a second. Approximately 25 percent of all infants born in Saskatchewan are low birth weight. Simple things like parity or close spacing double the risks."